Date _____ Patient Name (First) _____(Middle)___ (Last) _____ (Nickname)_____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ SSN _____ Sex (F) _____ (M) _____
Married ____ Single ____ Child ____ Email Address _____
Phone (Cell) _____ (Work) _____ (Home) _____
Emergency Contact Name & Phone Number _____
Please make sure to give us any updated insurance information you may have when checking in. Thanks.

HEALTH HISTORY (please indicate "yes" or "no")

Y	N		Y	N		Y	N	
○	○	AIDS/HIV	○	○	Cortisone/Steroid Treatment	○	○	High Blood Pressure
○	○	Anxiety/Nervous Problems	○	○	Diabetes (circle) type 1/type 2	○	○	Kidney Disease
○	○	Asthma	○	○	Drug/Alcohol Abuse	○	○	Liver Disease
○	○	Blood Disorder	○	○	Emphysema/Respiratory Disease	○	○	Low Blood Pressure
○	○	Anemia	○	○	Epilepsy	○	○	Migraines/Frequent Headaches
○	○	Other _____	○	○	Fainting/Dizziness	○	○	Premedicate (prior dental procedure)
○	○	Blood Thinners (i.e.-Coumadin, Warfarin, Aspirin)	○	○	Fen-Phen (Diet Pills)	○	○	Psychiatric Care
			○	○	Heart Problems	○	○	Rheumatic Fever
○	○	Bones/Joints	○	○	Artificial Heart Valves	○	○	Scarlet Fever
○	○	Arthritis/Rheumatism	○	○	Congenital Heart Lesions	○	○	Skin Rash
○	○	Artificial Joints	○	○	Heart Disease	○	○	Stroke
○	○	Other _____	○	○	Heart Murmur	○	○	Thyroid Problems
○	○	Cancer (type) _____	○	○	Mitral Valve Prolapse	○	○	Tuberculosis
○	○	Chemotherapy	○	○	Pacemaker	○	○	Tumor
○	○	Radiation Therapy	○	○	Other _____	○	○	Weight Loss, unexplained
○	○	Cold Sores/Fever Blisters/Herpes	○	○	Hepatitis (type)_____	○	○	Eating Disorder

Physician's Name _____ **Phone (_____)** _____
Emergency Contact _____ **Phone #** _____ **Pharmacy Name** _____**Phone #**_____
Have you had any recent surgeries/hospitalizations? (past 5 years) _____
Have you ever been told you needed an antibiotic prior to dental treatment? (Circle One) YES NO

ALLERGIES (please indicate "yes" or "no")

Y	N	
○	○	Aspirin
○	○	Barbiturates (Sleeping Pills)
○	○	Codeine
○	○	Flavoring Agents (i.e.-Mint/Cinnamon)
○	○	Iodine
○	○	Latex
○	○	Local Anesthetics/Epinephrine
○	○	Penicillin
○	○	Sulfa Other: _____

MEDICATIONS

Please list any medications you are currently taking and reason:

_____

_____

_____

WOMEN: Are you pregnant? Y N Due Date?_____
Are you nursing? Y N Taking Birth Control? Y N

BILLING: You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Additional methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lendor/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above. You may opt out of text billing by choosing "No" below. PLEASE INITIAL ONLY ONE ANSWER

Yes, I accept electronic billing via text _____ **(Initial)** No, I do not accept electronic billing via text _____**(Initial)**

CONTACT: You agree, in order for us to contact you regarding your appointments, our organization's representative and any 3rd party messaging systems we may use, may contact you by telephone at any telephone number associated with your account, text message and/or e-mail address you provide to us.

I acknowledge that if I do not give 24 hours notice of cancellation (by phone call), I am responsible for a $50 cancellation fee (subject to change).
I acknowledge that I (the patient), am responsible to know my insurance benefits, and benefits are not guaranteed until the insurance company has made payment.
I acknowledge that payment is due when services are rendered.
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for this activities and health care operations that are related to treatment.

Patient's / Parent's Signature _____ **Date** _____
(Acknowledgement of all the above statements)